TESTIMONY
to
Assembly Select Committee on Alcohol and Drug Abuse
Designing Effective Treatment Programs: Best Practices
Thursday, December 10, 2007
10:00 a.m. – 1:00 p.m.
Elihu Harris State Building Rm. 2
1515 Clay Street, Oakland, CA 94612

Best Practices in Co-occurring Substance and Mental Disorders (COD)

Testimony of
California Psychiatric Association
Richard Shadoan, MD

> "Health care for general, mental and substance-use problems and illness must be delivered with the understanding of the inherent interactions between the mind/brain and the rest of the body. Improving care delivery and outcomes for any one of the above depends upon improved care and outcomes for the other two."
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> ■ Institute of Medicine 2006, National Academy of Sciences
> "Improving Quality of Health care for Mental and Substance Use Disorders"

1. Prevalence of Co-occurring Substance and Mental Disorders (COD)

Mental Health Services Oversight and Accountability Commission: The OAC has found that one half of people in California with a mental disorder have a substance abuse disorder; and, one half of people with substance abuse disorders have a mental disorder.

Special subpopulations with high prevalence:

- Juvenile Inmates (estimates of ± 85%)
- Juveniles (need citation)
- Inmates in Jails and Prisons (estimates of ±70%)
- Homeless (estimates of ±75%)

COD = a special population requiring specialized treatments.

2. Integrated Treatment

Sequential treatment is less effective: i.e. trying to treat mental illness first, achieve medical stability, then treat substance abuse; or, treating the substance abuse issues first, then treating the mental illness.

Parallel treatment is less effective: i.e. the individual is treated in two separate settings, by two separate service providers or systems with little or no coordination of care. This is often counterproductive.

The evidence base is clear: Numerous studies demonstrated that integrated treatment is necessary for highly successful treatment of COD, and significantly more effective than sequential or parallel models of treatment.

Integrated treatment needed in both inpatient and outpatient care.

3. Public Sector Examples of Integrated Treatment

Mentally Ill Offender Crime Reduction grant demonstration programs. This successful statewide program, formerly (1999 -2002) administered by the Board of Corrections funded 30 grants in 26 counties, has now (2006) evolved into 44 programs administered by the Corrections Standards Authority (California Department of Corrections and Rehabilitation).

"Because the legislature provided that the counties would have flexibility to tailor the programs to fit local needs, there was a wide variety of programs that evolved. Regardless of their design, all the MIOCRG programs delivered

enhanced services that typically included [integrated] substance abuse education and treatment . . . . "[1]

Evaluation results which included matched control samples showed that a much higher percentage of the "treatment as usual" group than the "enhanced treatment" group had drug and alcohol problems at the end of the two-year program participation period (for drug problems, 55.3% versus 44.8% respectively; for alcohol problems, 49.6% versus 38.2% respectively).[2]

AB 2034 (Steinberg, 2000) – Assertive Community Outreach to Homeless Mentally Ill.

A successful ongoing state program blue penciled in the 2007-2008 budget had ongoing funding of $55 million statewide since 1999. AB 2034 programs provide comprehensive services to adults who have severe mental illness and who are homeless, at risk of becoming homeless, recently released from a county jail or the state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them. State funds for this program provide for outreach programs and services along with related medications, substance abuse and other services.[3] A little over 73% of the initial evaluation group presented with co-occurring substance use and mental illness.

The state Department of Mental Health report also indicated that the integrated treatment model of comprehensive services reduced the percentage of days hospitalized by 77.7% while the number of days of incarceration dropped 84.6% and the number of days spent homeless dropped 69.0%.[4]

[1] California's Ten-Year Homelessness Action Plan, June 23, 2006.
[2] Serial or parallel or no treatment for substance and alcohol use was the norm with treatment as usual.
[3] Welfare and Institutions Code Section 5806 et.seq.
[4] EFFECTIVENESS OF INTEGRATED SERVICES FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS (2004) A Report to the Legislature as Required by Assembly Bill (AB) 2034 Steinberg, Chapter 518, Statutes of 2000. California Department of Mental Health

CONREP – Conditional Release Program.

Integrated treatment forensic services programs contracted by the state Department of Mental Health to treat state hospital patients conditionally released into the community on civil commitments in several designated legal categories. Court sometimes approves placement of Incompetent to Stand Trial (IST) patients in a community program in lieu of, or after, a period of state hospitalization. CONREP reoffense rates are significantly less than the reoffense rate of a comparison group of patients who left hospitals in the past but without CONREP aftercare. Only 5% of Not Guilty by Reason of Insanity (NGRI) persons are rearrested during their first year of CONREP community exposure, while Mentally Disordered Offenders (MDO) had low rates of rearrest while in CONREP treatment, 10.6% during one year of community CONREP exposure. Finally, CONREP patients demonstrate very low levels of substance abuse while in the program.[5]

4. Evolution, Criminal Justice System: Drug, Mental Health and Behavioral Health Courts

Mental Health Courts.

The prevalence of COD in forensic populations is high, and has been addressed by a series of evolving community collaborative courts. Mental Health courts are a more recent innovation, compared to drug courts, and respond to crises in community mental health care and the long-term effects of de-institutionalization, the drug epidemic of the 1980s and 1990s, dramatic increases in homelessness, and pandemic jail overcrowding. Mental health courts or mental health court calendars have been identified in 27 jurisdictions.[6] To date, although there is good data to show that drug courts are cost-effective and improve outcomes[7], mental health courts are just starting to be studied. The crossover of mental and substance disorders is

[5] Wiederanders, M.R., Bromley, D.L., and Choate, P.A. (1997). Forensic conditional release programs and outcomes in three states. International Journal of Law and Psychiatry, 20, 2, 249-257.
[6] LA Times Article, Shutting Door to Treatment, December 7, 2007.
[7] **JUDICIAL COUNCIL OF CALIFORIA,** Collaborative Justice Courts Advisory Committee Report, February 7, 2003.

widely recognized and as a consequence most mental health courts are more properly termed behavioral health courts that apply an integrated treatment model.

A 2007 UCSF study of the San Francisco Behavioral Health Court demonstrates that the court reduces recidivism, new charges and violent offenses.[8] Citywide Forensic Services, which provides mental health services for the San Francisco Behavioral Court, indicates that 90% of the court population of 100 that they serve for the San Francisco court has a co-occurring substance and mental disorder.[9]

CFS uses the assertive community treatment (ACT) model which provides both the treatment for mental disorders and substance use within a multidisciplinary team utilizing: integrated group therapy; co-competent individual clinicians; and utilize residential treatment beds and other inpatient beds that are COD specific.

5. Mental Health Service Act (Proposition 63)[10]

Proposition 63 was a ballot initiative that was approved by 53.7% of the voters in November 2004, and provided a new funding stream of a surtax of 1% on taxable incomes over $1 million, with a new philosophy of recovery and an integrate, multidisciplinary approach to care for individuals with severe mental illness.

Mental Health Service Act (MHSA) community service and support programs are called Full Service Partnerships and are targeted to individuals who:

include those with a co-occurring substance abuse disorder and/orhealth

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[8] Dale E. McNiel and Renée L. Binder, Am J Psychiatry 2007 164: 1395-1403
Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence

[9] Telephone conversation between the Program Director and CPA Staff, December 7, 2007

[10] Welfare and Institutions Code Section 5800 various et.seq.

conditions—who are not currently being served and are homeless and/or involved in the criminal justice system. Individuals who are so underserved that they are at imminent risk of homelessness, criminal justice involvement of institutionalization, frequent users of hospitals and emergency room services, transition age adults between the ages of 50 and 59 who are aging out of the adult system and are at risk of any of the specified poor outcomes.

The MHSA community services and supports programs are in the early stages of implementation. The MHSA requires that outcome data be collected on the results of the integrated approach in FSP programs and services, but the data collection system is also not online at this time.

6. Kaiser Permanente: Open Door, Unlimited Substance Use Treatment

Kaiser Permanente, which exemplifies an integrated health, mental health and substance treatment model, provides unlimited substance abuse treatment because it is cost effective saving more in physical health care than is spent on full spectrum substance abuse treatment

(please see the testimony of David Pating, MD, for full details)

7. Private Insurance as a Barrier to Integrated Treatment in the Private Sector

Generally current private insurance substance abuse benefits "do not provide the same protection afforded under medical-surgical benefits in the private group insurance market - characterized by higher cost sharing and annual limits and lifetime limits on inpatient and outpatient care. These limits generally do not exist for other medical conditions and have increased since 1990."[11] At the same time, through the Mental Health Insurance Parity law (AB 88, Thomson, 2000), private health insurance and delivery plans are now

[11] *Health Affairs*, 26, no. 4 (2007): w474-w482

required to provide mental health benefits on the same terms and conditions as other health conditions. There is no comparable mandate for substance use treatment in the private sector – a serious oversight. Without the guarantee of substance use benefits on the same terms and conditions as health and mental health benefits, the private sector faces a huge obstacle in providing integrated care. AB 423 (Beall), though vetoed by the Governor in 2007, provides an equitable solution and should be revisited.

8. Challenges Providing Integrated Care in the Future

- Private health plans must be required to provide full scope substance abuse services benefits in addition to full scope mental health benefits at parity with other physical disorders.

- California's prison system must be required to adopt an integrated treatment model that focuses on rehabilitation and recovery both within prison facilities but also as an integral part of parole services in California communities.